MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ◆ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 25, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar right discectomy at L3-4 (63030) at Northwest Hills Surgical Hospital.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ **Overturned (Disagree)**

☐ Partially Overturned (Agree in part/Disagree in part)

The requested lumbar right discectomy at L3-4 (63030) is medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on XX/XX/XX. His injury occurred while he was lifting and twisting X at work. Past surgical history was positive for lumbar spine surgery in 1981. The 7/8/15 through 8/7/15 progress reports documented ongoing low back pain radiating into the right lower extremity with give-way weakness and numbness. Conservative treatment was documented to include activity modification, anti-inflammatory medications, heat, and exercise. A right L4 and L5 transforaminal epidural steroid injection was performed on 7/31/15. The 8/18/15 physical therapy report cited low back pain radiating into the right anterior thigh and medial leg to the calf with significant numbness. Pain was aggravated by walking or standing due to right leg weakness, and relieved by rest. Physical exam documented a very antalgic gait

with inability to walk/move into transitional activities due to leg weakness. There was mild to moderate loss of lumbar range of motion. He was unable to squat. Muscle testing documented weakness in right ankle dorsiflexion, bilateral hip flexion, bilateral knee extension, left ankle eversion, and right hip abduction. Straight leg raise was positive on the right. There was decreased right L2, L3, and L4 dermatomal sensation. Right patellar reflex was absent. The diagnosis was lumbar disc herniation with myelopathy. Physical therapy was planned for 7-10 visits. The 8/18/15 electromyography/nerve conduction velocity (EMG/NCV) report cited a history of constant severe back pain radiating into the right leg with weakness. The patient had been treated with medications, time, physical therapy, and injection with no relief. Magnetic resonance imaging (MRI) showed a disc extrusion at L4-5 compressing the nerve root at that level on the right and correlated with symptoms. Physical exam documented right hip flexion and knee extension weakness, absent right patellar reflex, and diminished right L4 dermatomal sensation. The electrodiagnostic impression documented evidence of severe acute L5 radiculopathy on the right side. The 8/20/15 orthopedic report cited complaints of low back pain with severe right leg radiculopathy and weakness. He was using crutches due to on-going pain. He had tried medications and injections. The orthopedic surgery documented review of the 6/25/15 MRI which showed multilevel degenerative disc protrusions with a new right extruded disc herniation at L3-4. There was electrodiagnostic evidence of severe acute L4 radiculopathy. Physical exam documented lateral thigh pain with lumbar flexion and extension. There was decreased anterolateral thigh sensation on the right. There was weakness in the right quadriceps and ankle dorsiflexor. His reflexes were decreased in the patella and equal at the Achilles. The provider noted the patient had good conservative care with therapy, medications, injections, and time. The patient's symptoms had been present and worsening for xxxxx and given the MRI and EMG/NCV findings, the provider recommended surgical decompression in the form of discectomy was warranted at the L3-4 level on the right.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated The URA denial documentation dated 10/23/15 indicates that the documentation submitted for review does not indicate that the patient has failed conservative treatment to include physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) criteria for lumbar discectomy include symptoms/findings that confirm the presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. For the L3-4 level, guidelines require one of the following findings, severe unilateral quadriceps weakness/mild atrophy, mild to moderate unilateral quadriceps weakness, or unilateral hip/thigh/knee pain. Guideline criteria include imaging evidence of nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment including activity modification for at least two months, drug therapy (non-steroidal anti-inflammatory drugs (NSAIDs), other analgesic therapy, muscle relaxants, epidural steroid injection), and support provider referral (physical therapy for home exercise instruction, manual therapy, or psychological screening). In this case, ODG criteria have been met. The patient presents with constant severe low back pain radiating into the right lower

extremity with associated numbness and weakness. Signs and symptoms are consistent with an L3-4 radiculopathy. Clinical exam findings include right quadriceps weakness, diminished right L4 dermatomal sensation, absent patellar reflex, and positive straight leg raise. Clinical findings correlate with imaging findings of an extruded disc herniation at L3-4 and electrodiagnostic evidence of severe acute L4 radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, the requested lumbar right discectomy at L3-4 is medically necessary. In accordance with the above, I have determined that the requested lumbar right discectomy at L3-4 (63030) at Northwest Hills Surgical Hospital is medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**